MENTAL HEALTH MANUAL

MONTANA MEDICAID
&
MONTANA MENTAL HEALTH SERVICES PLAN

October 2003

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A. MONTANA MENTAL HEALTH SERVICES PLAN

July 1, 1999, the State initiated the Mental Health Services Plan (MHSP). An individual is eligible for covered services under the plan if:

(a) the individual is a youth under the age of 18 years with a serious emotional disturbance (SED) or an adult with a severe disabling mental illness (SDMI); and the family of which the individual is a member has a total family income, without regard to other family resources, at or below 150% of the most recently published federal poverty level (FPL);

(b) the individual has been denied Medicaid eligibility, is ineligible for Medicaid by virtue of being a patient in an institution for mental diseases, or has applied for Medicaid and the application is pending. An individual who meets Medicaid eligibility requirements but does not apply for Medicaid is not eligible to receive services under the plan;

(c) the individual is under the age of 19 years and the individual has been denied enrollment in Montana children's health insurance program (CHIP), as established in ARM Title 37, chapter 79;

(d) the individual is an adolescent who has met the eligibility requirements of the plan as a youth with serious emotional disturbance, but who will not meet the eligibility requirements of the plan as an adult with severe and disabling mental illness. The individual may continue to be eligible as an adolescent for the purpose of transition to independent living until the age of 21, provided the individual continues to meet income requirements

Eligibility for MHSP for adults is determined by a licensed mental health center under contract with the Department. Effective October 1, 2003 the contracted mental health centers are Western Montana Community Mental Health Center, Golden Triangle Community Mental Health Center, South Central Montana Community Mental Health Center, and Eastern Montana Community Mental Health Center. An applicant may contact one of the contracted agencies to obtain and complete a financial application. If the applicant is financially eligible, the mental health center will complete a clinical assessment to determine SDMI. If clinically eligible, MHSP eligibility is established for one year effective the date that the financial application was received by the mental health center.

Financial eligibility for individuals under the age of 18 is determined by the Department. If the applicant is not eligible for CHIP, but financially eligible for MHSP, a clinical assessment will be requested to determine SED. If clinically eligible, MHSP eligibility is established for one year effective the date that the financial application was received by the Department.

Individuals who qualify for the Mental Health Services Plan will receive an Identification Card that must be presented to providers when mental health services or prescriptions are received. **Note**: the MHSP identification card is not a guarantee of eligibility or of provider payment. Providers must verify MHSP eligibility by one of the methods listed in the "ELIGIBILITY INFORMATION" section of this manual.

An individual may have both Medicaid and MHSP cards simultaneously. The Medicaid card should always be used in that case. **Providers must bill Medicaid in preference to the Mental Health Services Plan if an individual has both types of eligibility**.

Services covered under the MHSP are listed in the "COVERAGE" section of this manual. The MHSP will cover only services performed in treatment of a principal diagnosis listed as a covered diagnosis in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services (excluding pharmacy) provided to individuals 18 years of age and older.

B. ENROLLMENT/PROVIDER NUMBERS

ACS will enroll mental health providers. Information concerning enrollment is available at www.mtmedicaid.org. Providers without internet access may contact the Provider Relations Unit at 1-800-624-3958 (in state) or 1-406-442-1837 (out-of-state). A provider must have an active provider number in order to submit a claim for reimbursement.

Pharmacy providers should also enroll as MHSP providers in order to be eligible for reimbursement for services provided under the MHSP program. Please call the Provider Relations Unit for information.

Some providers may have different provider numbers assigned for different types of mental health services they are providing. If you do have multiple provider numbers, please make sure that you use the correct provider number for the services being billed.

C. CODING REQUIREMENTS

When coding for Montana Medicaid and for the Mental Health Services Plan be aware that CPT-4 codes and modifiers, including their respective definitions, are developed by the American Medical Association for providers to describe their services numerically for claim submission to insurers.

Montana DPHHS requires the use of uniform procedure and diagnosis coding on all claims. CPT codes 90801 through 90857 are face-to-face and may be billed with only one (1) unit of service for each date of service. The procedure code must accurately reflect the time spent with the patient.

Fees and covered codes for each provider type are available at www.mtmedicaid.org or can be obtained by written request to the ACS Provider Relations Unit at P.O. Box 8000, Helena, MT 59604 or fax (406) 442-4402.

The Department's goal is to pay claims as quickly and efficiently as possible. To attain this goal, a computer processes claims. This automated method does not include review by medical personnel or detailed evaluation for appropriate billing procedures.

The automated system detects many billing errors and denies claims accordingly. However, this process is not conclusive. **Providers are responsible for billing their services correctly.** Standard use of coding conventions, particularly those established in the most current editions of the ICD-9-CM and CPT-4 and HCPCS Level II manuals, are required of the provider when billing Medicaid and the MHSP. Providers should become familiar with these manuals as DPHHS relies on them when setting its coding policies.

DO NOT ASSUME THAT PAYMENT OF A CLAIM MEANS THE SERVICE WAS BILLED OR PAID CORRECTLY. ALL CLAIMS ARE SUBJECT TO POST-PAYMENT REVIEW AND POSSIBLE RECOVERY OF OVER-PAYMENTS.

D. PROVIDER MANUALS

Detailed information on billing, reimbursement, limitations and other requirements are contained in the provider manuals distributed by ACS for each provider type, and those provider manuals take precedence over this manual where conflicts may exist for Montana Medicaid services. All providers should also receive *"General Information for Providers"* and *"General Information for Providers II"* distributed by ACS and available at www.mtmedicaid.org.

If you bill for services using the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations. If you bill for services on the UB-92 claim form, the *Montana UB-92 Reference Manual* is available from the Montana Hospital Association. You may contact the Montana Hospital Association by calling 406-442-1911 or by writing to the Association at P.O. Box 5119, Helena, MT 59604.

Providers are required to provide services in accordance with Federal regulations, Montana State law, Administrative Rules, and any applicable licensure standards. In the event of a conflict between Federal regulations, Montana State Law, Administrative Rules, or any applicable licensure standards and this Manual, the former will prevail.

E. THIRD PARTY COVERAGE, CHILDRENS HEALTH INSURANCE PLAN, AND MEDICARE

When they exist, other financial resources must be identified on the claim form. The other resource must be billed before the provider files a claim with ACS. When billing ACS secondary, the provider must report the amount paid by the other resource or submit a photocopy of the statement of denial from the other resource. The denial must list the insurance company name, patient name, date of service, amount billed and complete reason for denial. Please refer to your provider handbook (*"General Information for Providers II"*) available at www.mtmedicaid.org.

Claims for individuals who are dually Medicare/Medicaid eligible will be paid taking into consideration the psychiatric reduction from Medicare. Medicare mental health crossovers will price at the lower of Medicare allowed minus the Medicare paid or Medicaid allowed minus the Medicare paid.

F. SURVEILLANCE/UTILIZATION REVIEW

The Department is charged by Federal and State law to identify, investigate, and refer to the Medicaid Fraud Control Unit of the Department of Justice all cases of suspected fraud or abuse in Medicaid by either providers or clients. Please refer to your *"General Information for Providers Manual"* for additional information and requirements regarding surveillance/ utilization review.

G. COVERAGE

Mental health services delivered by the following provider types will be covered under Montana Medicaid. For detailed information on reimbursed services, see the appropriate provider category under the "SERVICES" section of this manual.

Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services (excluding pharmacy) provided to individuals 18 years of age and older.

Program	Coverage		Prior Auth	Billing Form
	Medicaid	MHSP		
Inpatient Hospital	Y	N	Y	UB-92
Outpatient Hospital / Emergency Room	Y	N	N	UB-92
Partial Hospitalization	Y	Y	Y	UB-92
Mental Health Centers	Y	Y	Some	CMS-1500
Physicians	Y	Y	N	CMS-1500
Psychiatrists	Y	Y	N	CMS-1500
Psychologists	Y	Y**	N	CMS-1500
Related Laboratory and X-Ray	Y	Y	N	CMS-1500
Mid Level Practitioners	Y	Y	N	CMS-1500
Social Workers	Y	Y**	N	CMS-1500
Licensed Professional Counselors	Y	Y**	N	CMS-1500
Residential Treatment Centers	Y	N	Y	UB-92
Therapeutic Group Homes	Y	N	Y	CMS-1500
Therapeutic Family Care	Y	N	Y	CMS-1500
School Based Services	Y	N	N	CMS-1500
Pharmacy & Related Lab Services	Y	Y	Some*	Point-of-sale or MA-5
Case Management	Y	Y***	N	CMS-1500
Institution for Mental Disease	Y	Y	N	MA-3/TAD
Home Health Services	Y	N	N	UB-92
Personal Care	Y	N	N	CMS-1500
Indian Health Services	Y	N	N	UB-92
Federally Qualified Health Centers	Y	N	N	UB-92
Rural Health Clinics	See page 42	See page 42	N	UB-92

*Some prescriptions will require prior authorization

**Psychologist, social worker, and LCPC services are available for MHSP adults only through a licensed mental health center under contract with the Department for MHSP services
***Adult only

H. COVERED DIAGNOSES

Coverage for Montana Mental Health Services Plan services and prescriptions will be strictly limited to treatment provided for the principal diagnosis listed below. Claims submitted with a principal diagnosis other than one listed as covered will be denied under the MHSP. All claims are subject to retrospective review for diagnostic accuracy.

Covered ICD-9-CM Diagnosis Codes for the Mental Health Services Plan

Covered Diagnoses	Excluded Diagnoses
290.0 through 290.9	291.0 through 292.9
293.0 through 301.9	302.0 and 302.1
302.2	302.3
302.4	302.50 through 302.53
302.6	302.70 through 302.83
302.84 through 302.89	302.9
306.0 through 306.9	307.0
307.1 through 307.3	307.40 through 307.45
307.46	307.47 through 307.49
307.50 through 307.80	307.81
307.82 through 312.30	312.31
312.32 through 314.9	315.00 through 315.9
316	

For Montana Medicaid beneficiaries there is no restriction on coverage by diagnosis, but all Medicaid services must be medically necessary for the treatment of the diagnosis entered on the claim form. Medicaid beneficiaries must have been determined to have either a severe and disabling mental illness (adult) (ARM 37.86.3502) or a serious emotional disturbance (youth) (ARM 37.86.3702) in order to receive most covered mental health services. Mental health services for Medicaid clients are limited to services in treatment of a primary or principal diagnosis that is a "covered" diagnosis. This limitation applies to provider types which are exclusively mental health providers: mental health centers, intensive case managers, psychologists, social workers, professional counselors, residential treatment centers, partial hospitalization programs, therapeutic group care and therapeutic family care.

ACS's claims processing system will only accept valid **ICD-9-CM** diagnosis codes. A crosswalk between the covered ICD-9-CM codes and DSM-IV codes has been developed and is available at www.mtmedicaid.org or by contacting ACS Provider Relations.

I. PRIOR AUTHORIZATION AND CONTINUED CARE REVIEW

Certain mental health services listed in the "COVERAGE" section of this manual always require prior authorization. Claims for those services, rendered to Medicaid or MHSP beneficiaries, will be denied payment without prior authorization.

All requests for prior authorization and continued stay authorization must be sent to:

First Health Services
Telephone: 1-800-770-3084
Fax: 1-800-639-8982 or 1-800-247-3844

A copy of the First Health Services Provider Manual and revised forms are available on the Department's website (http//www.dphhs.state.mt.us).

If an individual's principle diagnosis at the time of discharge is a covered psychiatric diagnosis, and was not indicated as the admitting diagnosis, the facility must contact First Health Services for a retrospective authorization.

Claims for services that require prior authorization must have the prior authorization number indicated in the appropriate field on the claim form. Providers must bill Medicaid according to the information supplied on the prior authorization. Each line on the claim must match the line information on the authorization with respect to dates of service, procedure code, and units of service.

For providers who bill using the CMS-1500 claim form, if the prior authorization issued has three lines of service, the provider must bill with three individual **lines** on the claim form that match the three lines on the prior authorization. A prior authorization number may have up to 21 claim lines.

For providers who bill using the UB-92 claim form, if the prior authorization issued has three lines of service, the provider must bill three individual UB-92 **claim forms** for each line of service indicated on the prior authorization.

Those mental health services not requiring prior authorization will be subject to retrospective review by the Department for medical necessity and appropriateness.

J. COST SHARING and CLIENT RESPONSIBILITY

Mental health services provided to individuals eligible for Medicaid will be subject to the cost sharing requirements published for individuals eligible for services under Montana Medicaid. Individuals eligible for mental health services through the Mental Health Services Plan are subject to cost sharing for pharmacy services.

Clients are responsible for the designated cost sharing amounts. Clients are informed of the cost sharing requirements at the time they are determined eligible for Medicaid or for the MHSP. Providers are responsible for collecting cost sharing payments.

CHILDREN (*under age* 21), PREGNANT WOMEN, AND NURSING HOME RESIDENTS ARE EXEMPT FROM MEDICAID COST SHARING. Cost share amounts may not be charged to a Medicaid client for services provided during an emergency. Cost share amounts may not be charged when Medicare or another third party is the primary payer for the service.

Providers are required to accept, as payment in full, the amount paid by the Montana Medicaid program for a service provided to an eligible client. A provider may bill a client for noncovered services if the provider has informed the client in advance of providing the services that Medicaid will not cover the services and that the client will be required to pay privately for the services, and if the client has agreed to pay privately for the services. The client must be informed of the specific service and date of service for which he/she will be responsible for payment. Noncovered services are those that may not be reimbursed for the particular client by the Montana Medicaid program under any circumstances. Covered services are those that may be reimbursed by the Montana Medicaid program for the particular client if all applicable requirements, including medical necessity, are met.

A provider may not bill a client after Medicaid has denied payment for covered services because the services are not medically necessary unless the provider specifically informed the client in advance of providing the services that the services are not considered medically necessary under Medicaid criteria, that Medicaid will not pay for the services and that the client will be required to pay privately for the services, and the client has agreed to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the client indicating that the service will not be paid by Medicaid. The provider may not bill the client when the provider has informed the client only that Medicaid may not pay or where the agreement is contained in a form that the provider routinely requires clients to sign.

A provider may not bill a client for services when Medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing or other requirements necessary to obtain payment. (ARM 37.85.406(11)).

K. ELIGIBILITY INFORMATION

Whenever possible, the provider should view the patient's ID card and verify eligibility information using one of the methods described below.

The MHSP identification card is not proof of eligibility or guarantee of payment. Providers must verify MHSP eligibility since eligibility can expire at the end of any month. For example, some MHSP eligible individuals that have MHSP eligibility in July will not be eligible in August. Providers should verify MHSP eligibility every month. Effective October 1, 2003 MHSP adult services will be reimbursed only to mental health centers under contract with the Department.

There are a number of resources available to providers for the verification of Medicaid and MHSP eligibility. These include the Medicaid Eligibility and Payment System (MEPS), Automated Voice Response and FAXBACK.

Providers can access Medicaid and MHSP eligibility through the Internet by using the Medicaid Eligibility and Payment System (MEPS). MEPS is available via the 'Medicaid' kiosk in the DPHHS room of the Virtual Human Services Pavilion at http://vhsp.dphhs.state.mt.us. To access MEPS, you must first receive a password from DPHHS. This can be done by printing the MEPS Access Request Form from the MEPS site and mailing it to DPHHS. The MEPS Security Officer will contact you to verify your request and to give you your MEPS password. You will be required to change your password the first time you log on to MEPS.

Another option is to call Automated Voice Response at 1-800-714-0060 or FAXBACK at 1-800-714-0075. Voice Response will let you know if a Medicaid or MHSP client has eligibility for a particular date of service. You must have your provider number, client identification number, and date of service available. FAXBACK will fax a report of the client's eligibility including managed care details, insurance coverage, Medicare coverage, etc. To sign up for FAXBACK, call ACS at 1-800-624-3958 in state and (406) 442-1837 in Helena and out-of-state. Have your provider number and FAX number ready when you call.

Providers will be given an audit number when contacting ACS and the AVRS for eligibility. Providers will be responsible for keeping the audit number on file in case there may be discrepancies regarding eligibility during claims processing.

L. MEDICAID CLIENTS ON PASSPORT

Medicaid clients who are covered through PASSPORT do **not** need a referral from their primary care provider to access mental health services. These mental health services will be paid through the Medicaid fee-for-service mental health program. All requirements of the mental health program, including prior authorization, apply to PASSPORT enrollees obtaining mental health care.

M. MAINTENANCE OF RECORDS

All providers of mental health services must maintain records which fully demonstrate the extent, nature and medical necessity of services provided to Medicaid and MHSP clients which support the fee charged or payment sought and which demonstrate compliance with applicable requirements. These records must be retained for a period of at least 6 years and 3 months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later. (ARM 37.85.414)

The Department, designated review organization, the legislative auditor, the Department of Public Health and Human Services, the Department of Revenue, the Medicaid fraud control unit, and their legal representatives shall have the right to inspect or evaluate the quality, appropriateness, and timeliness of services performed by providers, and to inspect and audit all records required by ARM 37.85.414.

N. SERVICES

1. Inpatient Hospital

♦ Requirements

Inpatient hospital services are those items and services ordinarily furnished by a hospital for the care and treatment of inpatients. Services must be provided under the direction of a licensed practitioner in an institution maintained primarily for treatment and care of patients with disorders other than tuberculosis or mental illness. The institution must be currently licensed by the designated state licensing authority in the state where the institution is located and must meet the requirements for participation in Medicare as a hospital.

♦ Prior Authorization

All inpatient hospital services for psychiatric diagnosis require prior authorization through First Health Services. If the admitting diagnosis is not psychiatric, but the discharge diagnosis is psychiatric, contact First Health for retroactive authorization.

♦ Billing/Reimbursement

All claims for inpatient hospital services provided to Medicaid beneficiaries must be submitted on a UB-92 form. **Reimbursement will not be made to hospitals for inpatient hospital services provided to MHSP beneficiaries.** However, physician charges which are billed separately will be covered.

For further information on service coverage and billing requirements for inpatient services to Medicaid beneficiaries, please refer to the *Montana Medicaid Inpatient Hospital Manual.* For assistance in completing the UB-92 claim form, the *Montana UB-92 Reference Manual* is available from the Montana Hospital Association. You may contact the Association by calling 406-442-1911 or by writing the Association at P.O. Box 5119, Helena, MT 59604.

2. Outpatient Hospital

♦ Requirements

Outpatient hospital services are those preventive, diagnostic, therapeutic, rehabilitative, and palliative items or services provided to an outpatient under the direction of a physician, dentist, or other practitioner. Outpatient hospital services must be provided by an institution licensed as a hospital by the designated state licensing authority in the state where the institution is located and that meets the requirements for participation in Medicare as a hospital.

Outpatient means a person who has not been admitted by a hospital as an inpatient, who is expected by the hospital to receive services for less than 24 hours, who is registered on the hospital records as an outpatient, and who receives outpatient hospital services, other than supplies alone.

- **Prior Authorization**

Prior authorization is not required for outpatient hospital services.

- **Billing/Reimbursement**

Outpatient hospital services for mental health diagnosis will be reimbursed on the Ambulatory Payment Classification (APC) after August 1, 2003, if applicable, or based on a fee established by the Department. Claims must be submitted on a UB-92 form. **Reimbursement will not be made to hospitals for emergency room services or observation beds provided to MHSP beneficiaries.** However, physician charges which are billed separately will be covered.

Reimbursement of outpatient hospital services provided to MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

For further information, please refer to the *Montana Medicaid Outpatient Hospital Manual*. For assistance in completing the UB-92 claim form, the *Montana UB-92 Reference Manual* is available from the Montana Hospital Association. You may contact the Association by calling 406-442-1911 or by writing the Association at P.O. Box 5119, Helena, MT 59604.

3. Partial Hospitalization

Partial hospitalization means an active treatment program that offers therapeutically intensive, coordinated, structured clinical services provided only to individuals who are determined to have a serious emotional disturbance (youth) or severe disabling mental illness (adult). (ARM 37.86.3001(7))

- **Requirements**

Full day programs will require provision of services for a minimum of six (6) hours per day, five (5) days per week. Half-day programs will require provision of services for a minimum of four (4) to six (6) hours per day, four (4) days per week.

Acute level partial hospitalization is provided by programs that are operated by a hospital with a distinct psychiatric unit and are co-located with that hospital such that in an

emergency a patient of the acute partial hospitalization program can be transported to the hospital's inpatient psychiatric unit within 15 minutes. Acute level partial hospitalization programs serve primarily individuals being discharged from inpatient psychiatric treatment or residential treatment and are designed to stabilize patients sufficiently to allow discharge to a less intensive level of care, on average, after 15 or fewer treatment days.

Sub-acute level partial (SAP) hospitalization is provided by programs that operate under the license of a general hospital with a distinct psychiatric unit or an inpatient psychiatric hospital for individuals under the age of 21. SAP hospitalization programs operate in a self-contained facility and offer integrated mental health services appropriate to the individual's needs as identified in an individualized treatment plan.

♦ Certificate of Need and Prior Authorization

A Certificate of Need must be completed for all Medicaid or MHSP beneficiaries who request Partial Hospitalization Services. A team that includes a physician who has competency in the diagnosis and treatment of mental illness, preferably in psychiatry, and has knowledge of the individual's condition; a licensed mental health professional; and an intensive case manager must complete the certificate. The team must certify that:

a) The client is experiencing psychiatric symptoms of sufficient severity to create moderate to severe impairments in educational, social, vocational, and/or interpersonal functioning;
b) The client cannot be safely and appropriately treated or contained in a less restrictive level of care;
c) Proper treatment of the client's psychiatric condition requires acute treatment services on an outpatient basis under the direction of a physician;
d) The client can be safely and effectively managed in a partial hospital setting without significant risk of harm to self/others; and
e) The services can reasonably be expected to improve the client's condition or prevent further regression.

- Certificate of Need – Signature and Date (ARM37.86.2801)

For individuals determined to be Medicaid or MHSP eligible at the time of admission, the Certificate of Need must be completed, signed, and dated prior to, but no more than 30 days before, admission.

For clients determined Medicaid eligible by the Department after admission to or discharge from the facility, the Certificate of Need must be completed, signed and dated within 14 days after the eligibility determination for clients determined eligible during the stay in the facility; or 90 days after the eligibility determination for clients determined eligible after discharge from the facility.

For clients who are transferred from a hospital's acute inpatient program to the same facility's partial hospitalization program, the certificate of need may be completed by a facility-based team of health care professionals that has knowledge of the client's psychiatric condition.

All partial hospitalization services require prior authorization through First Health Services for psychiatric diagnosis codes. When full-day partial hospitalization is requested and authorized, First Health Services will also enter an authorization for an equal number and span of half-day partial hospitalization. This will allow the partial hospitalization provider to bill only for half-day service when the individual can only be present for a half-day session.

- **Billing/Reimbursement**

Claims must be submitted on a UB-92 form. For assistance in completing the UB-92 claim form, the *Montana UB-92 Reference Manual* is available from the Montana Hospital Association. You may contact the Association by calling 406-442-1911 or by writing the Association at P.O. Box 5119, Helena, MT 59604.

Partial hospitalization services must be billed under revenue code 912 and must include a Montana specific procedure code in the HCPCS field (form locator 44) on the UB-92 form.

For Partial Hospitalization services, use Code H0035 with the appropriate modifier.

Service	Procedure Code	Modifier
Acute Partial Hospitalization – Full Day	H0035	U8
Acute Partial Hospitalization – Half Day	H0035	U7
Sub-acute Partial Hospitalization – Full Day	H0035	U6
Sub-acute Partial Hospitalization – Half Day	H0035	

Reimbursement for Partial Hospitalization is based on a bundled rate that includes all of the services associated with the psychiatric diagnosis. These services include psychologists, social workers and licensed professional counselors, and medications received during treatment. Physicians and psychiatrists are the only providers allowed to bill separately for their services.

Reimbursement of Partial Hospitalization services provided to MHSP beneficiaries will be made only for service provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective

October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

4. Institution for Mental Disease

♦ Requirements

Institution for mental disease means a hospital, nursing facility, or other institution with more than 16 beds which the Department of Public Health and Human Services has determined is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. An institution for the mentally retarded, including an intermediate care facility for the mentally retarded, is not an institution for mental diseases.

Mental disease means a disease listed as a mental disorder in the current edition of the Diagnostic and Statistical Manual of Mental Diseases but does not include mental retardation, senility and organic brain syndrome.

An institution for mental disease, as a condition of participation in the Montana Medicaid or MHSP programs, must be a nursing facility that meets the following requirements (ARM37.88.1405):

a) complies with the requirements of ARM 37.40.306 for Medicaid nursing facility service providers;

b) has been determined by the Department to be an institution for mental diseases;

c) complies with ARM 37.40.352 regarding utilization review and quality of care for nursing facilities, and;

d) enters into and maintains a written agreement with the Department that specifies the respective responsibilities of the Department and the provider.

♦ Individual Treatment Plan

Institutions for mental diseases providing services must provide for and maintain recorded individual plans for treatment and care to ensure that institutional care maintains the client at, or restores the client to, the greatest possible degree of health and independent functioning. The plans must include:

a) designation for needed care at a level higher than personal care;

b) an initial review of the client's medical, psychiatric and social needs within 30 days after the date of admission;

c) periodic review of the client's medical, psychiatric and social needs;

d) a determination at least every 90 days of the client's need for continued institutional care and for alternative care arrangements;

e) appropriate medical treatment in the institution; and

f) appropriate social services.

♦ **Billing/Reimbursement**

The Montana Medicaid or MHSP programs will reimburse for services provided for clients age 65 or over or clients under 21 receiving nursing facility services in a nursing facility that the Department has determined to be an institution for mental diseases. Reimbursement calculation will be in accordance with the rules adopted by the Department for institutions for mental diseases (ARM37.88.1410).

Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The Department will pay a provider on a monthly basis the amount determined under rules established by the Department upon receipt of an appropriate billing which reports the number of patient days provided to authorized clients during the billing period. Institution for mental disease providers will bill on the Department MA-3 for these per diem amounts.

5. Mental Health Centers

♦ **Benefits and Limitations**

Mental health center services include the following:

a) Practitioner Services include inpatient and outpatient therapy provided by licensed mental health professionals, including physicians, mid-level practitioners, psychologists, social workers, and licensed professional counselors. Practitioner services are subject to the respective requirements of each provider type.
b) In-training practitioner services provided under the supervision of a licensed practitioner by an individual who has competed all academic requirements for licensure. Services are subject to the same requirements that apply to licensed practitioners.
c) Adult day treatment (clinic service)
d) Child and adolescent day treatment (clinic service)
e) Comprehensive School and Community Treatment
f) Community Based Psychiatric and Rehabilitation Support
g) Crisis Intervention Facility
h) Family care for mentally ill adults
i) Adult group home services
j) Adult and youth respite care (limited)

k) Mental Health Adult Group Home Therapeutic Home Visits and Mental Health Adult Family Care Therapeutic Home Visits. No more than 14 days per individual in each rate year will be allowed for therapeutic home visits. For purposes of the 14-day limit, all therapeutic home visits must be included

l) Adult intensive community based rehabilitation facility

m) Program of Assertive Community Treatment (PACT)

Clinic Physician Requirements

Adult and child/adolescent day treatment services are clinic services. Coverage of clinic services is limited to services furnished under the direction of a physician. This requirement does not mean that the physician must be an employee of the clinic, or be utilized on a full time basis or be present in the facility during all hours that services are provided. Each patient's care must, however, be under the supervision of a physician directly affiliated with the clinic.

To meet this requirement, a physician must see the patient at least once, prescribe the type of care provided, and, if the services are not limited by the prescription, periodically review the need for continued care. Although the physician does not have to be on the premises when the patient is receiving covered services, the physician must assume professional responsibility for the services provided and assure that the services are medically necessary and appropriate.

Thus, physicians, who are affiliated with the clinic, must spend as much time in the facility as is necessary to assure that patients are getting services in a safe and efficient manner in accordance with accepted standards of medical practice. Clinic affiliation requires a contractual agreement or some other type of formal arrangement between the physician and the facility by which the physician is obligated to supervise the care provided to the clinic's patients.

Some clinics will have patients whose numbers and acuity require more physician involvement than one person can provide. The size of the clinic and the type of services it provides should be used to determine the number of physicians that must be affiliated with a clinic to meet the physician direction requirement. Also, each clinic must have medical staff that is licensed by State law to provide the medical care delivered to its patients.

♦ **Billing/Reimbursement**

Mental health centers are required to bill CPT-4 for services provided by physicians, mid-level practitioners, psychologists, social workers, professional counselors and in-training practitioners. Reimbursement will be according to the Department’s RBRVS fee schedule, adjusted for the provider type.

Please refer to the appropriate provider-type descriptions in the “SERVICES” section of this manual for additional information. For assistance in completing the CMS-1500 claim

form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

The following HCPCS codes will be accepted by Montana Medicaid and must be billed on the CMS-1500 in block 24d:

Procedure	Modifier	Service
S5150	HB	Respite Care - Adult, per 15 minute unit
S5150	HA	Respite Care - Youth, per 15 minute unit
S5102		M.H. Group Home – Adult, per day
S5102	U5	MH Adult Group Home Therapeutic Home Visit
S5140		Adult Family Care - per day
H0036		Comprehensive School & Community Treatment per 15-minute increment
S5140	U5	MH Adult Family Care Therapeutic Home Visit
H2012	HB	Day Treatment – Adult, per hour
H2012	HA	Day Treatment – Youth, per hour
H2019		Community-Based Psychiatric Rehabilitation & Support – Individual, per 15 minute increment
H2019	HQ	Community-Based Psychiatric Rehabilitation & Support -- Group, per 15 minute increment
S9485		Crisis Intervention, per day
S5120	HE	Intensive Community Based Rehabilitation
H0040		Program of Assertive Community Treatment (PACT)

These procedures will be paid according to the Department's published fee schedule. Comprehensive School and Community Treatment is provided by a public school district that is a licensed mental health center or a school district that has a contract with a licensed mental health center.

Psychiatrists and other physicians billing with a mental health center provider number are eligible for reimbursement for Evaluation and Management services provided to Medicaid or Mental Health Services Plan beneficiaries. Please utilize the CPT-4 for complete descriptions and coding guidelines for Evaluation and Management services.

An updated Fee Schedule that will include these new services for Mental Health Center Psychiatrist/Physician Services is available at www.mtmedicaid.org or by writing to ACS Provider Relations, P.O. Box 4936, Helena, MT 59604.

Mental health providers, including physicians, psychiatrists, mid-level practitioners, mental health centers, psychologists, social workers, and professional counselors may use modifier 22 in certain situations. This modifier designates services as being unusual or prolonged. Providers should use it only when a diagnostic interview examination or crisis assessment meets those criteria (CPT 90801, 90802), and providers should carefully document the crisis response services or prolonged assessment, including time spent with the client, and the specific services provided.

Providers should submit their usual and customary charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that your usual and customary charge for this particular service must not be more than you would charge a private pay patient or another payer.

Only one unit of service is allowed for 90801. Providers may not bill 90801 on one line and 90801-22 on another line. The diagnostic interview or crisis response service constitutes one service and should be reported on one line using 90801 or 90802, as appropriate, billed with the 22 modifier, if necessary.

Reimbursement of services provided to MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid Program. Failure to use valid diagnosis and procedure codes will result in claims being denied. NOTE: DSM-IV CODES ARE NOT VALID IN THE MEDICAID CLAIMS PROCESSING SYSTEM.

6. Physician Services

Reimbursement for mental health services will be in accordance with the RBRVS schedule established by the Department. Claims must be submitted on a CMS-1500 form. Please refer to the *Physician Related Services Manual* for additional billing instructions. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

Reimbursement of physician services provided to MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Mental health providers, including physicians, psychiatrists, mid-level practitioners, mental health centers, psychologists, social workers, and professional counselors may use modifier 22 in certain situations. This modifier designates services as being unusual or prolonged. Providers should use it only when a diagnostic interview examination or crisis assessment meets those criteria(CPT 90801, 90802), and providers should carefully document the crisis response services or prolonged assessment, including time spent with the client, and the specific services provided.

Only one unit of service is allowed for 90801. Providers may not bill 90801 on one line and 90801-22 on another line. The diagnostic interview or crisis response service constitutes one service and should be reported on one line using 90801 or 90802, as appropriate, billed with the 22 modifier.

Only under very unusual circumstances would the "22" modifier be appropriate for clinical assessments for Mental Health Service Plan eligibility. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Providers should submit their usual and customary charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that your usual and customary charge for this particular service must not be more than you would charge a private pay patient or another payer.

7. Psychiatrists

Physicians who practice psychiatry must be board certified or board eligible and licensed by the State of Montana or in the state where they maintain their practice and enrolled as a psychiatrist with Montana Medicaid.

Reimbursement is 125% of the RBRVS fee schedule for physicians for dates of service beginning September 1, 2000. Reimbursement of psychiatrist services provided to MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Claims must be submitted on a CMS-1500 form. Please refer to the *Physician Related Services Manual* for additional billing instructions. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

The Department of Public Health and Human Services has determined that mental health providers, including physicians, psychiatrists, mid-level practitioners, mental health centers, psychologists, social workers, and professional counselors may use modifier 22 in certain situations. This modifier designates services as being unusual or prolonged.

Providers should use it only when a diagnostic interview examination or crisis assessment meets those criteria(CPT 90801, 90802), and providers should carefully document the crisis response services or prolonged assessment, including time spent with the client, and the specific services provided.

Only one unit of service is allowed for 90801. Providers may not bill 90801 on one line and 90801-22 on another line. The diagnostic interview or crisis response service constitutes one service and should be reported on one line using 90801 or 90802, as appropriate, billed with the 22 modifier.

Only under very unusual circumstances would the "22" modifier be appropriate for clinical assessments for Mental Health Service Plan eligibility. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Providers should submit their usual and customary charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that your usual and customary charge for this particular service must not be more than you would charge a private pay patient or another payer.

8. Mid-Level Practitioners

Reimbursement for Mid-Level Practitioners will be at 90% of the physician's reimbursement for patients age 21 and over, and at 100% of the physician's reimbursement for patients under age 21 for all mental health services.

Reimbursement of mid-level practitioner services provided to MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Claims must be submitted on a CMS-1500 form. Please refer to the *Physician Related Services Manual* for additional billing instructions. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

Mental health providers, including physicians, psychiatrists, mid-level practitioners, mental health centers, psychologists, social workers, and professional counselors may use modifier 22 in certain situations. This modifier designates services as being unusual or prolonged. Providers should use it only when a diagnostic interview examination or crisis assessment meets those criteria(CPT 90801, 90802), and providers should carefully

document the crisis response services or prolonged assessment, including time spent with the client, and the specific services provided.

Only one unit of service is allowed for 90801. Providers may not bill 90801 on one line and 90801-22 on another line. The diagnostic interview or crisis response service constitutes one service and should be reported on one line using 90801 or 90802, as appropriate, billed with the 22 modifier.

Only under very unusual circumstances would the "22" modifier be appropriate for clinical assessments for Mental Health Service Plan eligibility. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Providers should submit their usual and customary charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that your usual and customary charge for this particular service must not be more than you would charge a private pay patient or another payer.

9. Psychologist Services

Psychologist services are those services provided by a licensed psychologist, which are within the scope of the practices of the profession as provided for in Title 37, Chapter 17, of the Montana Codes Annotated.

The Department will pay psychologists 62% of the RBRVS fee schedule for physicians for covered CPT codes 90801 through 90857. The Department will reimburse psychologists 100% of RBRVS for CPT codes 96100, 96105, 96115, and 150% of RBRVS for 96117. Coverage is limited to diagnosis and treatment of a mental health condition. Educational services are not covered. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Psychologists will be required to bill on a CMS-1500 form using CPT codes approved by the Department. Appendix B lists the CPT-4 codes which are reimbursable for psychologists. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available from ACS Provider Relations.

Effective January 1, 2003 individual and family outpatient therapy is limited to a total of 16 sessions per year for individuals 18 years of age and older. Individuals under the age of 18 are limited to 24 sessions per year, and can receive additional medically necessary sessions with prior authorization. Group therapy sessions are not counted in the limited sessions. A group may not have more than eight (8) patients. Reimbursement of psychologist services provided to MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only

licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid Program. Failure to use valid diagnosis and procedure codes will result in claims being denied. NOTE: DSM-IV CODES ARE NOT VALID IN THE MEDICAID CLAIMS PROCESSING SYSTEM.

Mental health providers, including physicians, psychiatrists, mid-level practitioners, mental health centers, psychologists, social workers, and professional counselors may use modifier 22 in certain situations. This modifier designates services as being unusual or prolonged. Providers should use it only when a diagnostic interview examination or crisis assessment meets those criteria, (CPT 90801, 90802) and providers should carefully document the crisis response services or prolonged assessment, including time spent with the client, and the specific services provided.

Only one unit of service is allowed for 90801. Providers may not bill 90801 on one line and 90801-22 on another line. The diagnostic interview or crisis response service constitutes one service and should be reported on one line using 90801 or 90802, as appropriate, billed with the 22 modifier.

Providers should submit their usual and customary charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that your usual and customary charge for this particular service must not be more than you would charge a private pay patient or another payer.

When an eligible child receives psychologist services and the provider works with the parent as part of the child's treatment, the time with the parent may be billed to Medicaid under the child's name using CPT 90846. The provider must indicate on the claim that the child is the client, state the child's diagnosis, and indicate the therapy session was with the parent, but that the focus of the session was the child.

A FAMILY THERAPY SESSION MUST NOT BE BILLED UNDER MORE THAN ONE FAMILY MEMBER'S MEDICAID OR MHSP NUMBER. The family member must be Medicaid or MHSP eligible on the date of service.

Medicaid covers inpatient psychologist services as part of the inpatient payment rate in the following circumstances:

a) when services are provided by psychologists who are employed by the hospital or under contract with the hospital involving consideration; and

b) when services are part of discharge planning as required under 42 CFR 482/21(b) or other services, such as group therapy, which are required as part of licensure or certification of the hospital.

All other inpatient services provided by a psychologist are a benefit, up to the limits specified in this manual.

Claims must be submitted on a CMS-1500 form. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

10. Social Workers

Licensed Clinical Social Worker (LCSW) services are those services provided by a LCSW, which are within the scope of the practice of the profession as provided for in Title 37, Chapter 2, of the Montana Codes Annotated.

The Department will pay social workers 62% of the RBRVS rate for physicians. Coverage is limited to diagnosis and treatment of a mental health condition. Educational services are not covered.

Social workers will be required to bill on a CMS-1500 form using CPT codes approved by the Department. Appendix C lists the CPT-4 codes which are reimbursable for social workers. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available from ACS Provider Relations.

Effective January 1, 2003 individual and family outpatient therapy is limited to a total of 16 sessions per year for individuals 18 years of age and older. Individuals under the age of 18 are limited to 24 sessions per year, and can receive additional medically necessary sessions with prior authorization. Group therapy sessions are not counted in the limited sessions. A group may not have more than eight (8) patients.

Reimbursement of social worker services provided MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Valid ICD-9-CM diagnosis codes must also be used in billing the Montana Medicaid Program. Failure to use valid diagnosis and procedure codes will result in claims being denied. NOTE: DSM-IV CODES ARE NOT VALID IN THE MEDICAID CLAIMS PROCESSING SYSTEM.

Mental health providers, including physicians, psychiatrists, mid-level practitioners, mental health centers, psychologists, social workers, and professional counselors may use modifier 22 in certain situations. This modifier designates services as being unusual or prolonged. Providers should use it only when a diagnostic interview examination or crisis assessment meets those criteria, (CPT 90801, 90802) and providers should carefully

document the crisis response services or prolonged assessment, including time spent with the client, and the specific services provided.

Only one unit of service is allowed for 90801. Providers may not bill 90801 on one line and 90801-22 on another line. The diagnostic interview or crisis response service constitutes one service and should be reported on one line using 90801 or 90802, as appropriate, billed with the 22 modifier.

Providers should submit their usual and customary charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that your usual and customary charge for this particular service must not be more than you would charge a private pay patient or another payer.

When an eligible child receives social worker services and the provider works with the parent as part of the child's treatment, the time with the parent shall be billed to Medicaid under the child's name using CPT 90846. The provider shall indicate on the claim that the child is the client, state the child's diagnosis, and indicate the therapy session was with the parent, but that the main focus of the session is the child.

A FAMILY THERAPY SESSION MUST NOT BE BILLED UNDER MORE THAN ONE FAMILY MEMBER'S MEDICAID NUMBER. The family member must be Medicaid eligible on the date of service.

Medicaid covers inpatient social worker services as part of the inpatient payment rate in the following circumstances:

a) when services are provided by social workers who is employed by the hospital or under contract with the hospital involving consideration; and

b) when services are part of discharge planning as required under 42 CFR 482/21(b) or other services, such as group therapy, which are required as part of licensure or certification of the hospital.

All other inpatient services provided by a social worker are a benefit, up to the limits specified in this manual.

11. Licensed Clinical Professional Counselors

Licensed Professional Counselor (LPC) services are those services provided by a LPC which are within the scope of the practices of the profession as provided for in Title 37, Chapter 23, of the Montana Codes Annotated.

The Department will pay licensed professional counselors 62% of the RBRVS rate for physicians. Coverage is limited to diagnosis and treatment of a mental health condition. Educational services are not covered.

Professional counselors will be required to bill on a CMS-1500 form using CPT codes approved by the Department. Appendix C lists the CPT-4 codes which are reimbursable for professional counselors. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available from ACS Provider Relations.

Effective January 1, 2003 individual and family outpatient therapy is limited to a total of 16 sessions per year for individuals 18 years of age and older. Individuals under the age of 18 are limited to 24 sessions per year, and can receive additional medically necessary sessions with prior authorization. Group therapy sessions are not counted in the limited sessions. A group may not have more than eight (8) patients.

Reimbursement of licensed professional counselor services provided MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual. Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Valid ICD-9-CM diagnosis codes must be used in billing the Montana Medicaid Program. Failure to use valid diagnosis and procedure codes will result in claims denial. NOTE: DSM-IV CODES ARE NOT VALID IN THE MEDICAID CLAIMS PROCESSING SYSTEM.

Mental health providers, including physicians, psychiatrists, mid-level practitioners, mental health centers, psychologists, social workers, and professional counselors may use modifier 22 in certain situations. This modifier designates services as being unusual or prolonged. Providers should use it only when a diagnostic interview examination or crisis assessment meets those criteria, (CPT 90801, 90802) and providers should carefully document the crisis response services or prolonged assessment, including time spent with the client, and the specific services provided.

Only one unit of service is allowed for 90801. Providers may not bill 90801 on one line and 90801-22 on another line. The diagnostic interview or crisis response service constitutes one service and should be reported on one line using 90801 or 90802, as appropriate, billed with the 22 modifier.

Providers should submit their usual and customary charge for the crisis response service or initial intake examination they are providing. Federal guidelines require that your usual and customary charge for this particular service must not be more than you would charge a private pay patient or another payer.

When an eligible child receives LPC services and the provider works with the parent as part of the child's treatment, the time with the parent may be billed to Medicaid under the child's name using CPT 90846. The provider must indicate on the claim that the child is

the client and state the child's diagnosis and indicate the therapy session was with the parent, but that the main focus of the session is the child.

A FAMILY THERAPY SESSION MUST NOT BE BILLED UNDER MORE THAN ONE FAMILY MEMBER'S MEDICAID OR MHSP NUMBER. The family member must be Medicaid eligible on the date of service.

Medicaid covers inpatient professional counselor services as part of the inpatient payment rate in the following circumstances:

a) when services are provided by professional counselor who are employed by the hospital or under contract with the hospital involving consideration; and

b) when services are part of discharge planning as required under 42 CFR 482/21(b) or other services, such as group therapy, which are required as part of licensure or certification of the hospital.

All other inpatient services provided by a professional counselor are a benefit, up to the limits specified in this manual.

12. Inpatient Psychiatric Services (for persons under the age of 21): Inpatient Psychiatric Hospital and Residential Treatment Center Services

Inpatient psychiatric services are services provided in an inpatient psychiatric hospital facility or residential treatment facility that is devoted to the provision of inpatient psychiatric services for persons under the age of 21.

Inpatient Psychiatric Services are those services which are provided in accordance with the Code of Federal Regulations, 42 CFR 441 Subpart D - Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs. The following requirements apply to facilities providing inpatient psychiatric services (ARM 37.88.1105):

a) The facility must maintain a current license as a hospital or a residential treatment facility under the rules of the Department's Quality Assurance Division to provide inpatient psychiatric care or residential psychiatric care. If the facility is not located within the State of Montana, the facility must maintain a current license in the equivalent category under the laws in which the facility is located.

b) Maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), The Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or any other organization designated by the Secretary of the United States Department of Health and Human Services as authorized to accredit psychiatric hospitals or residential treatment facilities for Medicaid.

♦ **Certificate of Need and Prior Authorization**

- Certificate of Need – Requirements (ARM37.88.1116)

A Certificate of Need that complies with the requirements of 42 CFR, Part 441, Subpart D must be completed for all Medicaid beneficiaries who request inpatient psychiatric services. A team that includes a physician, who has competency in the diagnosis and treatment in mental illness, preferably in child psychiatry, and has knowledge of the individual's condition; a licensed mental health professional; and an intensive case manager must complete the certificate. The team must certify that:

a) ambulatory care resources available in the community do not meet the treatment needs of the child or youth;

b) proper treatment of the child/youth's psychiatric condition requires services on an inpatient basis under the direction of a physician; and

c) the services can reasonably be expected to improve the child/youth's condition or prevent further regression so that services will no longer be needed.

- Certificate of Need – Signature and Date

For individuals determined to be Medicaid eligible at the time of admission, the Certificate of Need must be completed, signed by team members, and dated prior to, but no more than 30 days before, admission.

For clients determined Medicaid eligible by the Department after admission to or discharge from the facility, the Certificate of Need must be completed, signed and dated within 14 days after the eligibility determination for clients determined eligible during the stay in the facility; or 90 days after the eligibility determination for clients determined eligible after discharge from the facility.

Prior authorization will be required prior to the youth's admission to inpatient psychiatric services. Authorization must be obtained from First Health Services.

For clients who are transferred between levels of inpatient psychiatric care within the same facility, the certificate of need may be completed by the facility-based team responsible for the plan of care within 14 days after admission provided that the certificate of need has been signed by an intensive case manager employed by a mental health center or other individual knowledgeable about local mental health services as designated by the department and admission has been authorized by the department or the department's designee.

- **Out-of-State Providers**

Reimbursement for residential treatment inpatient psychiatric services provided outside the state of Montana will be made only under the conditions specified in ARM 37.88.1106(8). Inpatient psychiatric services provided by residential treatment facilities located outside the state of Montana will only be authorized when the Department or its designee has determined that the services were unavailable in the state of Montana. Residential psychiatric care will not be determined to be unavailable in the state of Montana unless

a) the client has been officially screened for placement by all enrolled in-state residential treatment facility providers and denied admission because the facilities cannot meet the client's treatment needs; or

b) the client has been officially screened for placement by all enrolled in-state residential treatment facility providers and denied admission because a bed is not available, and the client's psychiatric condition prevents the client from being temporarily and safely placed in another setting while awaiting placement in an in-state residential treatment facility.

♦ **Therapeutic Leave**

Reimbursement will be made to a residential treatment facility provider for reserving a bed while the client is temporarily absent only if (ARM37.88.1106(11)):

a) the client's plan of care documents the medical need for therapeutic home visits;

b) the client is temporarily absent on a therapeutic home visit;

c) the provider clearly documents staff contact and client achievements or regressions during and following the therapeutic home visit;

d) the client is absent from the provider's facility for no more than 3 patient days per absence, unless the Department or its designee determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence; and

e) if the therapeutic home visit is in excess of 48 hours, the visit has been approved by the Department or its designee in advance of the visit. Requests for approval under the subsection must be received by the Department or its designee at least two (2) working days in advance of the start of the visit.

No more than 14 days per client in each rate year will be allowed for therapeutic home visits. For purposes of this 14-day limit, all therapeutic home visits must be included whether or not such visits were of sufficient length to require advance approval under (e).

The provider must report to the Department or its designee each therapeutic home visit of 48 hours or less within 30 days after the start of the visit. Each visit must be reported on a form approved by the Department.

Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the Addictive and Mental Disorders Division or its designee.

- **Billing/Reimbursement**

Reimbursement for inpatient psychiatric services provided by an inpatient psychiatric hospital facility **will not be made for inpatient psychiatric services provided to MHSP beneficiaries.**

Reimbursement for residential treatment services provided by in-state facilities to youths eligible for Medicaid will be based on a bundled rate which includes all services associated with the youth's psychiatric diagnosis, including educational costs. Physician services are to be billed separately.

Payment for inpatient psychiatric services provided outside the state of Montana will be made only under the conditions specified in ARM 37.85.207(3). Reimbursement for inpatient psychiatric services provided to Montana Medicaid clients in facilities located outside the state of Montana will be as provided in ARM 37.86.2905(1)(c).

Claims must be submitted on a UB-92 form. For assistance in completing the UB-92 claim form, the *Montana UB-92 Reference Manual* is available from the Montana Hospital Association. You may contact the Association by calling 406-442-1911 or by writing the Association at P.O. Box 5119, Helena, MT 59604.

For residential treatment services the following billing codes apply.

Revenue Code	Service
124	All inclusive RTC services
183	Therapeutic home visit

The day of discharge is not a patient day for purposes of reimbursement.

13. Therapeutic Group Homes

The therapeutic portion of medically necessary therapeutic youth group home treatment is covered for youth who have been determined to have a serious emotional disturbance (ARM37.86.3702) if treatment is ordered by a physician, licensed psychologist, licensed clinical social worker, or a licensed professional counselor, and prior authorized by the Department or its designee.

The therapeutic portion of moderate, campus-based, or intensive level therapeutic youth group home care is covered if the facility is licensed by and contracted with the Department to provide a specific level of care. If the therapeutic youth group home facility is not located within the state of Montana, the provider must maintain a current license in the equivalent category under the laws of the state in which the facility is located.

♦ Certificate of Need and Prior Authorization

A Certificate of Need must be completed for all beneficiaries who request therapeutic group home services. A team that includes a physician who has competency in the diagnosis and treatment of mental illness, preferably in psychiatry, and has knowledge of the individual's condition; a licensed mental health professional; and an intensive case manager must complete the certificate. (ARM 37.86.2219)

The certificate of need must certify the necessary level of care and, for intensive level services, must certify that five (5) of the following criteria are met, or for moderate or campus-based level services, must certify that four (4) of the criteria are met.
The team must certify that:

- Symptoms of the individual's emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service.
- The client exhibits behaviors related to the covered diagnosis that result in significant risk for psychiatric hospitalization or placement in a more restrictive environment if therapeutic living care is not provided or the person is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting.
- The prognosis for treatment of the individual's mental illness or emotional disturbance at a less restrictive level of care is very poor because the individual demonstrates three or more of the following due to the emotional disturbance or mental illness:
  - significantly impaired interpersonal or social functioning;
  - significantly impaired educational or occupational functioning;
  - impairment of judgment; or
  - poor impulse control.
- As a result of the emotional disturbance or mental illness, the individual exhibits an inability to perform daily living activities in a developmentally appropriate manner.

- As a result of the emotional disturbance or mental illness, the client exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

Certificate of Need – Signature and Date

For individuals determined to be Medicaid eligible at the time of admission, the Certificate of Need must be completed, signed, and dated prior to, but no more than 30 days before, admission.

For clients determined Medicaid eligible by the Department after admission to or discharge from the facility, the Certificate of Need must be completed, signed and dated within 14 days after the eligibility determination for clients determined eligible during the stay in the facility; or 90 days after the eligibility determination for clients determined eligible after discharge from the facility.

The therapeutic portion of therapeutic youth group home services must be authorized by the Department or its designee.

♦ **Therapeutic Home Visits**

Reimbursement will be made to a provider for reserving a therapeutic youth group home bed while the client is temporarily absent only if:

a) the client's plan of care documents the medical need for therapeutic home visits;
b) the client is temporarily absent on a therapeutic home visit;
c) the provider clearly documents staff contact and client achievements or regressions during and following the therapeutic home visit;
d) the client is absent from the provider's facility for no more than 3 patient days per absence, unless the Department or its designee determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence; and

No more than 14 days per client in each rate year will be allowed for therapeutic home visits. For purposes of this 14-day limit, all therapeutic home visits must be included.

The provider must report to the Department or its designee each therapeutic home visit within 30 days after the start of the visit. Each visit must be reported on a form acceptable to the Department.

Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the Addictive and Mental Disorders Division or its designee.

♦ **Billing/Reimbursement**

All services must be billed on the CMS 1500 form. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

For therapeutic group home services the following billing codes apply.

Procedure	Modifier		Service
S5145			Therapeutic Youth Group Home – Moderate Level, per day
S5145	TF		Therapeutic Youth Group Home – Campus-Based, per day
S5145	TG		Therapeutic Youth Group Home – Intensive Level, per day
S5145		U5	Therapeutic Home Leave – Moderate Level, per day
S5145	TF	U5	Therapeutic Home Leave – Campus Level, per day
S5145	TG	U5	Therapeutic Home Leave - Intensive Level, per day

Medicaid will not reimburse for room, board, maintenance, or any other non-therapeutic component of treatment.

14. Therapeutic Family Care (Foster Care)

The therapeutic portion of medically necessary therapeutic family care treatment is covered for youth who have been determined to have a serious emotional disturbance, as defined by the Department (ARM 37.86.3702), if the treatment is ordered by a physician, licensed psychologist, master's level licensed clinical social worker, or a licensed professional counselor.

The therapeutic portion of therapeutic family care is covered if the provider is licensed by and contracted with the Department to provide moderate therapeutic family care services.

Certificate of Need and Prior Authorization

A Certificate of Need must be completed for all Medicaid beneficiaries who request therapeutic family care services. A team that includes a physician who has competency in the diagnosis and treatment of mental illness, preferably in psychiatry, and has knowledge of the individual's condition; a licensed mental health professional; and an intensive case manager must complete the certificate.

The certificate of need must certify the necessary level of care and must certify that four (4) of the following criteria are met. (ARM 37.86.2221(2))

The team must certify that:

- Symptoms of the individual's emotional disturbance or mental illness are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental health service.
- The client exhibits behaviors related to the covered diagnosis that result in significant risk that the client will require psychiatric hospitalization or placement in a more restrictive environment if therapeutic living care is not provided or the client is currently being treated or maintained in a more restrictive environment and requires a structured treatment environment in order to be successfully treated in a less restrictive setting.
- The prognosis for treatment of the individual's mental illness or emotional disturbance at a less restrictive level of care is very poor because the individual demonstrates three or more of the following due to the emotional disturbance or mental illness:
    - significantly impaired interpersonal or social functioning;
    - significantly impaired educational or occupational functioning;
    - impairment of judgment; or
    - poor impulse control.
- As a result of the emotional disturbance or mental illness, the individual exhibits an inability to perform daily living activities in a developmentally appropriate manner.
- As a result of the emotional disturbance or mental illness, the client exhibits maladaptive or disruptive behavior that is developmentally inappropriate.

Certificate of Need – Signature and Date

For individuals determined to be Medicaid eligible at the time of admission, the Certificate of Need must be completed, signed by team members, and dated prior to, but no more than 30 days before, admission.

For clients determined Medicaid eligible by the Department after admission to or discharge from the facility, the Certificate of Need must be completed, signed and dated within 14 days after the eligibility determination for clients determined eligible during the stay in the facility; or 90 days after the eligibility determination for clients determined eligible after discharge from the facility.

The therapeutic portion of therapeutic family care services must be authorized by the Department or its designee.

Reimbursement will be made to a provider for reserving therapeutic youth family care bed, other than permanency therapeutic family care, bed while the client is temporarily absent only if:

a) the client’s plan of care documents the medical need for therapeutic home visits;
b) the client is temporarily absent on a therapeutic home visit;
c) the provider clearly documents staff contact and client achievements or regressions during and following the therapeutic home visit;
d) the client is absent from the provider’s facility for no more than 3 patient days per absence, unless the Department or its designee determines that a longer absence is

medically appropriate and has authorized the longer absence in advance of the absence; and

No more than 14 days per client in each rate year will be allowed for therapeutic home visits. For purposes of this 14-day limit, all therapeutic home visits must be included.

The provider must report to the Department or its designee each therapeutic home visit within 30 days after the start of the visit. Each visit must be reported on a form acceptable to the Department.

Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the Addictive and Mental Disorders Division or its designee.

♦ **Billing/Reimbursement**

All therapeutic family care services must be billed on the CMS 1500 form. For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

For therapeutic family care services the following billing codes apply.

Procedure	Modifier		Service
S5145	HR		Therapeutic Family Care – Moderate Level, per day
S5145	HE	TG	Permanency Therapeutic Family Care, per day
S5145	HR	U5	Therapeutic Home Leave – Moderate Level, per day

Note: Medicaid will not reimburse for room, board, maintenance, or any other non-therapeutic component of treatment.

15. Case Management for Adults with Severe and Disabling Mental Illness

Targeted case management services for adults (age 18 and older) with severe disabling mental illness (ARM 37.86.3502) are case management services provided by a licensed mental health center.

A client may not receive two or more types of case management services. For example, an individual must choose between case management under the Home and Community Based Services waiver and mental health targeted case management.

♦ **Covered Services**

Case management services for adults with severe and disabling mental illness include:

a) assessment;
b) case planning;

c) assistance in daily living;
d) coordination, referral and advocacy;
e) crisis response.

Case management services may include telephone services.

♦ **Requirements**

Prior authorization is not required for case management services.

Case management services must be supported by narrative documentation of all services provided.

Targeted case management services for adults with severe disabling mental illness must be provided according to a case management plan that must:

a) be developed jointly by the case manager and the client;

b) identify measurable objectives;

c) specify strategies to achieve defined objectives;

d) identify agencies and contacts that will assist in meeting the objectives;

e) identify natural and community supports to be utilized and developed; and

f) include an objective to serve the client in the least restrictive and most culturally appropriate therapeutic environment possible for the client which is also directed toward facilitating preservation of the client in the family unit, or preventing out-of-community placement or facilitating the client's return from acute or residential psychiatric care.

Objectives in an targeted case management plan must have an identified date of review no more than 90 days after the plan date. Plans will be revised to reflect changes in client goals and needs, and the services provided to the client.

♦ **Provider requirements**

Targeted case management for adults with severe disabling mental illness must be provided by a licensed mental health center with a license endorsement permitting the mental health center to provide targeted case management. Licensed mental health centers which have an endorsement to provide targeted case management services must enroll with ACS as a targeted case management provider of mental health services before any case management claims can be paid.

♦ Billing/Reimbursement

Targeted case management services for adults with severe disabling mental illness will be reimbursed according to the Department's fee schedule.

The Montana Medicaid program and the MHSP will not pay more than one provider for intensive case management services for the same period of time for the same client.

The Department will pay the lower of the provider's actual submitted charge or the Department's fee schedule for case management services for adults with severe disabling mental illness.

Case management services for adults will be reimbursed under the following procedure code by Montana Medicaid and the MHSP. They must be billed on the CMS-1500 in block 24d:

Procedure	Modifier	Service
T1016	HB	Targeted case management—Adult, 15 minute unit

For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

Reimbursement of case management services provided MHSP beneficiaries will be made only for services provided in treatment of a principal diagnosis that is a covered diagnosis as listed in the "COVERED DIAGNOSES" section of this manual.

Valid ICD-9-CM diagnosis codes must be used in billing the Montana Medicaid Program. Failure to use valid diagnosis and procedure codes will result in claims denial. NOTE: DSM-IV CODES ARE NOT VALID IN THE MEDICAID CLAIMS PROCESSING SYSTEM.

16. Case Management Services for Youth with Serious Emotional Disturbance

Targeted case management services for youth under the age of 18 years with a serious emotional disturbance are case management services provided by a licensed mental health center under contract with the Department for Targeted Youth Case Management.

A client may not receive two or more types of case management services. For example, an individual must choose between case management under the Home and Community Based Services waiver and targeted case management services.

♦ **Covered Services**

Case management services for youth with a serious emotional disturbance include:

a) assessment;
b) case planning;
c) assistance in daily living;
d) coordination, referral and advocacy; and
e) crisis response.

Case management services may include telephone services.

♦ **Requirements**

Prior authorization will not be required for case management services.

Case management services for youth with a serious emotional disturbance must be supported by narrative documentation of all services provided.

Targeted case management services for youth with a serious emotional disturbance must be provided according to a case management plan that must:

a) identify and define measurable objectives for the client and the client's family;
b) include an objective to serve the client in the least restrictive and most culturally appropriate therapeutic environment possible for the client which is also directed toward facilitating preservation of the client in the family unit, or preventing out-of-community placement or facilitating the client's return from acute or residential psychiatric care;
c) specify strategies for achieving defined objectives;
d) identify the strengths and potentials of the client and the client's family which will be a base upon which coordinated services will be provided;
e) identify agencies, service providers and contacts which will assist in achieving the defined objectives and specify how they will assist;
f) identify natural, family and community supports to be utilized and developed in achieving the defined objectives;
g) identify the role and duties of the client, the parent or the surrogate parent and all participants in the delivery of a comprehensive and coordinated service to the client and the client's family; and
h) specify monitoring procedures and time frames.

Objectives in a case management plan must have an identified date of review no more than every 90 days after the plan date. Plans must be kept current and revised to reflect changes in client goals and needs, the services provided to the client, and provider changes of responsibility.

♦ Provider Requirements

Targeted case management services for youth with a serious emotional disturbance must be provided by a licensed mental health center under contract with the Department with a license endorsement permitting the mental health center to provide targeted case management services to the population being served.

♦ Billing/Reimbursement

Targeted case management services for youth with a serious emotional disturbance are reimbursed according to the Department's fee schedule.

The Montana Medicaid program will not pay more than one provider for targeted case management services for the same period of time for the same resident.

The Department will pay the lower of the provider's actual submitted charge or the Department's fee schedule for case management services for youth with a serious emotional disturbance.

Montana Medicaid will reimburse youth case management services under the following procedure code. They must be billed on the CMS-1500 in block 24d:

Procedure	Modifier	Service
T1016	HA	Targeted case management – Youth - 15 minute unit

For assistance in completing the CMS-1500 claim form, please refer to the manual entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

Valid ICD-9-CM diagnosis codes must be used in billing the Montana Medicaid Program. Failure to use valid diagnosis and procedure codes will result in claims denial. NOTE: DSM-IV CODES ARE NOT VALID IN THE MEDICAID CLAIMS PROCESSING SYSTEM.

17. Services in Schools

School-based providers of mental health services must be individually enrolled under the applicable provider types with the specialty of '57' (school) or under the school provider number with the appropriate CSCT cohort. These provider types include licensed psychologists, licensed clinical social workers, and licensed clinical professional counselors. Educational services will not be covered. Please refer to the Physician Related Services Manual and the School-Based Services Provider Manual for additional billing instructions.

Services will be billed on a CMS-1500 form with the provider's customary billing code. For assistance in completing the CMS-1500 claim form, please refer to the manual

entitled *Completing the CMS-1500 Form* available at www.mtmedicaid.org or from ACS Provider Relations.

Prior authorization will not be required.

18. Pharmacy Services

♦ **Medicaid Pharmacy Program**

There is no change in processing pharmacy claims for Medicaid-eligible clients. Please refer to the current Medicaid Pharmacy Provider Manual for billing and reimbursement instructions.

♦ **Mental Health Services Plan**

The State of Montana has initiated a limited pharmacy benefit for individuals qualifying for the Mental Health Services Plan. This state-funded benefit has a very limited budget. It is imperative that prescribers and pharmacies assist the State in furnishing this group only with medications appropriate for the treatment of serious mental illnesses and serious emotional disturbance. We will rely upon Montana's knowledgeable providers to help contain the cost of medications and preserve this important benefit.

To request prior authorization, providers must submit the information asked for on the Request for Medicaid Drug Prior Authorization form to the Drug Prior Authorization Unit.

The prescriber (physician, etc.) or pharmacy provider may submit requests by mail, telephone, or FAX to:

DRUG PRIOR AUTHORIZATION UNIT
MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION
3404 COONEY DRIVE
HELENA, MT 59602

(406) 443-6002 or (800) 395-7961 (Phone)
(406) 443-4585 or (800) 497-8235 (Fax)

Requests will be reviewed and approvals or denials will be made, in most cases, immediately. Decisions on requests requiring further peer review because of unusual or special circumstances will be made within 24 hours. Requests received after the PA Unit's regular working hours of 8 AM to 5 PM Monday through Friday, or on weekends or holidays will be considered to be received at the start of the next working day.

If an after-hours/weekend/holiday request is for an emergency situation, an emergency 72-hour supply may be dispensed (by using three (3) in the days supply field and a Medical Certification code of eight (8) in the PA/MC code field). Payment will be authorized for these emergency supplies.

To receive payment for drugs requiring prior authorization, pharmacies must obtain approval from the Drug Prior Authorization Unit prior to dispensing the drug.

Coverage

Individuals qualifying for the Mental Health Services Plan receive a limited pharmacy benefit. The MHSP formulary is available both on the internet through www.mtmedicaid.org and in the *Mental Health Provider Manual* and the *Prescription Drug Program Manual.*

Prescriptions are limited to a 34-day supply. Refills may be dispensed after 75 % of a previous dispensing of the same prescription has been used, if taken according to the doctor's orders. Exceptions to this refill rule must be authorized by the Department.

Reimbursement

Reimbursement information is available in the *Prescription Drug Program Manual*

Billing

Billing information is available in the *Prescription Drug Program Manual*

For questions/problems, call ACS Provider Relations:

800-624-3958 (In State)
406-442-1837 (Out of State)

Co-Pay

Preferred Generic Drugs	$12.00/script
Preferred brand drugs only with generic available	$12.00/script
Brand name drugs with no generic	$12.00/script
Generic non-preferred	$17.00/script
Non-preferred Brand	$17.00/script
No co-pay for Clozaril and Clozapine	

Preferred products are drugs listed on the formulary for which the State of Montana has a rebate agreement with the drug manufacturer.

19. Indian Health Services

Indian Health Service providers may be reimbursed for mental health services for Medicaid clients. Indian Health Service providers should bill using the mental health encounter **revenue code 513** or the inpatient physician services **revenue code 987**.

20. Federally Qualified Health Centers (FQHC's)

Federally Qualified Health Center mental health services are a core service. FQHC providers should bill using core services **revenue code 529** for mental health services provided to Medicaid clients.

21. Rural Health Clinics (RHC's)

Rural Health Clinic mental health services are ambulatory services. Currently no RHC is providing mental health services, and the Department is not prepared to reimburse RHC's for mental health services. RHC's must notify the Department at least 30 days prior to offering a new category of ambulatory service to their patients. This will insure providers are aware, prior to providing new ambulatory services, of any limits, conditions, reimbursement amounts, etc…

22. Other Services

The following services will not be covered for MHSP clients. Programs listed below will be billed and reimbursed according to their respective manuals for Medicaid eligible individuals:

Program Name
Ambulance
Ambulatory Surgical Centers
Audiology
Case Management (Non-Mental Health)
Dental
Denturist
Durable Medical Equipment
Eyeglasses
Hearing Aids
Home and Community Based Services
Home Health
Hospice
Inpatient Hospital
Laboratory & X-Ray
Non-Emergency Transportation
Nursing Home
Optometric
Outpatient Hospital - Emergency Room
Personal Care
Physical Therapy
Podiatry
Private Nursing
Public Health Clinics
QMB Chiropractor
Speech Pathology
Swing Bed Hospital
Transportation & Per Diem

APPENDIX A

MONTANA MEDICAID AND MHSP CPT CODES FOR PSYCHOLOGIST SERVICES

The following information presents the CPT codes which a psychologist can bill for services provided to Medicaid clients and individuals eligible for the MHSP. Reimbursement for services are limited to the CPT codes listed below. Please use the appropriate modifiers when billing ACS. **Interactive psychotherapy codes are restricted to individuals 12 years of age and younger.**

Code	Description
90801	*Psychiatric diagnosis interview examination*
90802	*Interactive diagnosis interview using play equipment, physical devices, language interpreter, or other communication devices*
90804	*Individual psychotherapy insight oriented, behavior modifying and/or supportive, office or outpatient, 20 to 30 minutes*
90806	*Individual psychotherapy insight oriented, behavior modifying and/or supportive, office or outpatient, 45 to 50 minutes*
90810	*Individual psychotherapy interactive, using play equipment, physical devices or other mechanisms of non-verbal communications, office or outpatient, 20 to 30 minutes*
90812	*Individual psychotherapy interactive, using play equipment, physical devices or other mechanisms of non-verbal communications, office or outpatient, 45 to 50 minutes*
90816	*Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, 20 to 30 minutes*
90818	*Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, 45 to 50 minutes*
90823	*Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, inpatient hospital, partial hospital or residential care setting, 20 to 30 minutes*
90826	*Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, inpatient hospital, partial hospital or residential care setting, 45 to 50 minutes*
90846	*Family psychotherapy without patient*

Code	Description
90847	*Family psychotherapy with patient*
90849	*Multi-family group psychotherapy*
90853	*Group psychotherapy (other than multi-family)*
90857	*Interactive Group Therapy*
96100	*Psychological testing including psycho-diagnostic assessment of personality psychopathology, emotionality, intellectual abilities, per hour*
96105	*Assessment of Aphasia (includes assessment of expressive and receptive speech, and language function or comprehension), per hour*
96115	*Neurobehavioral status exam, per hour*
96117	*Neuropsychological testing battery, per hour*

When billing for the **clinical assessment** for MHSP eligibility determination, use procedure code 90801 or procedure code 90802.

Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Effective January 1, 2003 individual and family outpatient therapy is limited to a total of 16 sessions per year for individuals 18 years of age and older. Individuals under the age of 18 are limited to 24 sessions per year, and can receive additional medically necessary sessions with prior authorization. Group therapy sessions are not counted in the limited sessions. A group may not have more than eight (8) patients.

APPENDIX B

MONTANA MEDICAID AND MHSP CPT CODES FOR SOCIAL WORKER AND LICENSED PROFESSIONAL COUNSELOR SERVICES

The following information presents the CPT codes which a social worker and licensed professional counselor can bill for services provided to Medicaid clients and individuals eligible for the MHSP. Reimbursement for services are limited to the CPT codes listed below. Please use the appropriate modifiers when billing ACS. **Interactive psychotherapy codes are restricted to individuals 12 years of age and younger.**

Code	Description
90801	*Psychiatric diagnosis interview examination*
90802	*Interactive diagnosis interview using play equipment, physical devices, language interpreter, or other communication devices*
90804	*Individual psychotherapy insight oriented, behavior modifying and/or supportive, office or outpatient, 20 to 30 minutes*
90806	*Individual psychotherapy insight oriented, behavior modifying and/or supportive, office or outpatient, 45 to 50 minutes*
90810	*Individual psychotherapy interactive, using play equipment, physical devices or other mechanisms of non-verbal communications, office or outpatient, 20 to 30 minutes*
90812	*Individual psychotherapy interactive, using play equipment, physical devices or other mechanisms of non-verbal communications, office or outpatient, 45 to 50 minutes*
90816	*Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, 20 to 30 minutes*
90818	*Individual psychotherapy, insight oriented, behavior modifying and/or supportive, inpatient hospital, partial hospital or residential care setting, 45 to 50 minutes*
90823	*Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, inpatient hospital, partial hospital or residential care setting, 20 to 30 minutes*
90826	*Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, inpatient hospital, partial hospital or residential care setting, 45 to 50 minutes*
90846	*Family psychotherapy without patient*
90847	*Family psychotherapy with patient*

Code	Description
90849	*Multi-family group psychotherapy*
90853	*Group psychotherapy (other than multi-family)*
90857	*Interactive Group Therapy*
*96100**	*Psychological testing including psycho-diagnostic assessment of personality psychopathology, emotionality, intellectual abilities, per hour*

* 96100 is not payable to Licensed Clinical Social Workers

When billing for the **clinical assessment** for MHSP eligibility determination, use procedure code 90801 or procedure code 90802.

Effective October 1, 2003, only licensed mental health centers under contract with the Department will be reimbursed for MHSP services provided to individuals 18 years of age and older.

Effective January 1, 2003 individual and family outpatient therapy is limited to a total of 16 sessions per year for individuals 18 years of age and older. Individuals under the age of 18 are limited to 24 sessions per year, and can receive additional medically necessary sessions with prior authorization. Group therapy sessions are not counted in the limited sessions. A group may not have more than eight (8) patients.